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ABSTRACT

The objective of this study was to determine the feasibility of process-outcome evaluation in a broad-aim social program. Researchers collaborated with program staff to create outcome measures and measures of the services provided. Interventions for different groups of program participants were analyzed, using data on 122 children from kindergarten through fifth grade. Program participants having high initial levels of risk for child maltreatment received more information or support for relational services, information or support for legal services, referrals to financial services, referrals to health services, referrals to relational services, and referrals to legal services. In contrast, these program participants received less information or support for academic services than those with low initial risk. Families who achieved program goals received more interventions for academic services and more referrals to academic services. The findings support the effectiveness of process-outcome evaluation as applied to broad aim social programs. Program staff were able to complete the measures independently after training with evaluators, indicating that the design may be suitable for ongoing, long-term program evaluation. An appendix contains the study survey. (Contains 3 tables and 30 references.) (SLD)

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Measuring the Immeasurable:

Linking Interventions to Outcomes in a

Family Preservation Program Evaluation

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ABSTRACT

The objective of this study was to determine the feasibility of process-outcome evaluation in a broad-aim social program. Researchers collaborated with program staff to create outcome measures and measures of the services provided. Interventions for different groups of program participants were analyzed. Program participants having high initial levels of risk for child maltreatment received more information or support for relational services, information or support for legal services, referrals to financial services, referrals to health services, referrals to relational services, and referrals to legal services. In contrast, these program participants received less information or support for academic services than those with low initial risk. Families who achieved program goals received more interventions for academic services and more referrals to academic services. The findings support the effectiveness of process-outcome evaluation as applied to broad-aim social programs. Program staff were able to complete the measures independently after training with evaluators, indicating that the design may be suitable for ongoing, long-term program evaluation.

INTRODUCTION

In setting out to conduct a program evaluation, a researcher faces innumerable decisions. When evaluating a broad-aim social program, those innumerable decisions seem to multiply. It is tempting, therefore, to describe a population before and after completing "the program" and ignore the nature of the program. What "the program" is, however, will vary between clients:

> The client enters the box, something happens in there, the client leaves, and we study whether the client is different afterwards. But if you change what happens inside the magic box – if all these agencies and staff members differ in the way they work with families – then the study tells us very little ("Do-it-yourself prevention," 2000).

These "magic box" or "black box" evaluations compare program inputs and outputs; they are appropriate when interventions are standardized (Rogers, 2000). For broad-aim social programs such as family support, process-outcome evaluation may be more appropriate. Family preservation programs are flexible by nature and interventions vary by caseworkers, making "the program" different for each participant (Waldfogel, 1998).

Determining the range of treatments can be daunting and unwieldy. Researchers may choose to rely on case study data instead, implying that the process illustrated in a few cases is representative of the process for the population. Although an executable design plan, the danger here lies in a lack of data at the aggregate level. This may hinder decision-making and description of program goal attainment. Researchers have suggested that future program evaluations examine this relationship between process and outcome, as well as work to clarify definitions of risk, interventions, and outcomes (Faller & Ziefert, 1981; Heneghan, Horwitz, & Leventhal, 1996; Kinney & Dittmar, 1995;

Kumpfer, 1999; Mannarino & Cohen, 1990; Nelson & Landsman, 1992; Schwartz, 1995).

Chen and Rossi (1989) recommend that researchers "identify the processes linking program treatments and desired outcomes." We join a growing number of researchers driven by the desire to move away from the "black box evaluation" in which pre- and post-measures are taken without examining the relationship between treatment and outcomes (Owen & Fercello, 1999). Process-outcome evaluations document the services actually delivered before making evaluative statements regarding outcomes (Lipsey & Cordray, 2000; Rogers, 2000; Scheirer, 1994; Sechrest, West, Phillips, Redner, & Yeaton, 1979).

We had hoped to present linkages between interventions and outcomes for a family preservation program in this paper, however the evaluation is not yet at a stage where this can be done. Preliminary data has been collected and collaboration with program personnel has led to the development of both an online database for record keeping and a set of specific evaluation instruments to address funding questions using stakeholder input. This collaborative process is presented here with preliminary intermediate outcome data.

We believe that our collaborative methodology can be used to obtain useful results by accounting for differences in members of the population (risk levels) and actual treatment delivered (services). We further believe that making the data collection process concise and efficient will improve the utility of evaluation results (Patton, 1979; Schalock, 1995). The remainder of this paper documents our attempts to address these

concerns while conducting a process-outcome evaluation of a family preservation program.

RESEARCH QUESTIONS

1. Do families initially classified as high or low risk for child maltreatment receive different services?
2. Do families who achieve program goals receive different services than those who do not?

METHODOLOGY

Participants

Program. The Southeastern County Family Preservation Program (SCFPP) is a Department of Social Services program that aims to reduce the incidence of child outplacement due to abuse and neglect. The program staff includes a program coordinator, administrative assistant, and ten caseworkers based in fifteen rural, suburban, and urban elementary schools. Any community member may refer a family for services, although most referrals come from school personnel. Caseworkers contact potential program participants to establish a relationship and complete an eligibility assessment in which both risk factors and strengths are noted. If they are found eligible, families may elect to not participate. If they choose to participate, caseworker and family collaboratively create a case plan targeting factors that place the children at risk of maltreatment and outplacement. Families exit the program when they have achieved their goals, moved from the county, or withdrawn their consent to participate.

The SCFPP met with the Weldon-Cooper Center for Public Service at the University of Virginia (U.Va.) in 1999 and expressed an interest in evaluating the year-

old program. U.Va. researchers began by meeting with program staff and an evaluation steering committee comprised of stakeholder representatives from the Department of Social Services (DSS), U.Va., and the county public schools. After reviewing case files and visiting the school sites, the researchers spent six months assisting program staff in creating an online computer database that would maintain case files in a consistent manner. The steering committee guided these efforts and suggested that the researchers address the measurement of program goals, e.g. reduction of child maltreatment and outplacement. This paper addresses actions taken in response to this request.

Caseworkers. The program staff offer a broad range of experience to the SCFPP. Several caseworkers have master's degrees in social work, and one is currently pursuing a master's degree in education. Seven caseworkers have worked in DSS programs such as Child Protective Services (CPS) and the Child Health Insurance Partnership (CHIP). Other program staff have experience in family counseling or working in the schools.

Workers meet monthly as a group of ten, and in two working groups of five each more frequently. Working groups are led by an experienced supervising caseworker who provides support and guidance for group members. In general, caseworkers function as DSS representatives within the context of their respective elementary schools.

Program Participants. This paper analyzes data on 122 children participating in the SCFPP and their families. Of the 122 children in this sample, 20% were in kindergarten, 17% were in the first grade, 20% were in the second grade, 20% were in the third grade, 19% were in the fourth grade, and 4% were in the fifth grade. Sixty-one percent were

male. Fifty-six percent of the children were Caucasian, 36% were African-American, 6% were Biracial, and 7% were Hispanic.

Children are referred into the program by a referring source completing a confidential referral form. The children in the sample were referred to the SCFPP mainly by teachers (30%) and guidance counselors (18%). Thirteen percent were referred by caseworkers, 9% by principals/assistant principals, 5% by parents, 2% by other family members and 23% by other community agencies/partners. The average number of reasons for referral was four with the median being three and the mode being five.

The 122 children were members of 86 families. Caseworkers reported that 22% of families had been involved in family support or preservation programs before coming into the FSP. Fifty of the families had one child in the FSP, 31 families had two children in the program, and 5 families had three children in the program. Seventy-two percent of children in the sample had mothers as primary caregivers and a father was primary caregiver for 14% of children. The primary caregivers ranged in age from 23-56 years old with a mean age of 37, median of 36, and mode of 30 years. Primary caregiver education level ranged from no schooling to master's degree. The mean education level was one year of college beyond high school with the mode being high school graduate. Five primary caregivers had received a GED.

These primary caregivers held between zero and six jobs in the preceding calendar year, with the average being two jobs. The number of months caregivers were unemployed ranged from 0 – 12 in a calendar year with the average number of months unemployed being three and the median and mode both being zero.

Eighteen percent of families were reported to live in Section 8 public housing, 61% of families were reported as needing continuing support for basic needs, and 45% percent of families were reported to have an income less than their expenses. Seventy-nine percent of the children were receiving free or reduced lunches and 40% of children are receiving Medicaid.

Data Collection Procedures

Before researchers began data collection, program staff obtained written informed consent from program participants. It was emphasized that data collected during the evaluation would be used for program evaluation and improvement and that information would be kept confidential. The study protocols and consent forms were reviewed and approved by the University of Virginia Institutional Review Board for the Social Sciences (Project #2000-0234-00).

For each program participant, caseworkers completed a questionnaire pertaining to child maltreatment characteristics and history. Caseworkers recorded information on substantiated CPS referrals both prior to participating in the program and during program involvement. Workers referred cases for which they were uncertain of previous and/or current CPS status to the program coordinator who looked them up in the CPS records. Caseworkers also completed a checklist for each family participating in the program, estimating the number of times they provided or coordinated services over a three-month period.

Caseworkers agreed to meet with researchers and provide estimates of the interventions that they provided to program participants. Researchers were trained to

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collect this data on the two forms (Appendix A). All of the researchers collaborated in the creation of the checklist and sat on the Steering Committee that fine-tuned and approved the checklist.

During the pilot testing phase, the researchers discussed as a team the issues and questions that arose in the field with the entire team. This prepared researchers in advance for the types of questions that they would have to field and examples they would have to provide in order to have all caseworkers complete the form consistently.

Researchers met with caseworkers during October and November 2001. At this initial meeting, structured checklists were provided for all program participants that met the criteria for selection. Per the Steering Committee, data were to be collected on a sample of families participating in the program as of October 1, 2001. The researchers completed at least one structured checklist with caseworkers so that the task could be appropriately introduced and any questions could be answered. Every caseworker required supplemental directions that further described the task at hand above and beyond those listed on the checklist. In these additional directions researchers often provided additional exemplars, clarification of specific services and/or service delivery modes, and answers to preliminary questions that acquainted caseworkers with which service delivery mode was appropriate for the situations they described.

Caseworkers provided estimates on the structured checklist of how and how often they provided program participants with the specific services listed on the checklist. Caseworkers generally had access to the program's online database in which they maintain case records. They also referred to their contact logs, written case file narratives, and personal calendars.

Measures

Child Abuse and Neglect Form. We developed the Child Abuse and Neglect Form in collaboration with the steering committee and program staff to serve as a measure of child abuse and neglect characteristics of families participating in the SCFPP. When we began working with program staff and the evaluation steering committee to identify the goals and intended outcomes of the program we found that much of the matter was undecided. Staff agreed that the program's aim was to help families improve however they could. Consensus on specific outcomes, however, was elusive. Researchers investigated the program's funding stream and collected documentation from various stages of program development. The requirements laid out by the funding source stated that funded programs must ultimately report data on changes in child maltreatment levels.

Researchers sought input from the director of CPS as well as program staff to create the measure of child maltreatment and outplacement history. Feedback was considered during steering committee meetings and incorporated into draft forms. Initially, we had hoped to administer the entire Child Abuse Potential Inventory to each caregiver as the instrument is highly regarded in the child welfare field and offers strong evidence of reliability. The program coordinator and researchers decided that due to the Inventory's length and the need to have caregivers rather than caseworkers complete it, this was not feasible. We instead adapted the instrument to meet our needs by constructing 11 questions based on the Inventory that could be answered by caseworkers based on their observations of the family.

The Child Abuse and Neglect Form was piloted by four of the ten caseworkers. Each worker completed the service checklist on one of his or her participating families. Once the form was completed, the Worker was asked to provide suggestions on how the checklist could be improved upon. A second pilot test was conducted in which caseworkers completed the checklist for one family, noting difficulties and confusions. Final changes were made based on this information.

The final form consisted of 17 questions pertaining to the caseworker's knowledge of child maltreatment factors present in the family. Workers reported information on the substantiation of CPS referrals for children prior to and since coming into the SCFPP. They also noted reasons for CPS referral and case outcomes. Workers responded to two similar questions about child placement outside of the home prior to and since coming into the program. Workers rated the level of child supervision during the week and on the weekend using two Likert scales. Finally, caseworkers completed the series of 11 Likert scale questions about their perceptions of caregiver behavior loosely based on Milner's (1996) Child Abuse Potential Inventory.

Children and families were classified as "high initial risk" or "low initial risk" based on substantiated CPS referral or lack of substantiated CPS referral prior to participating in the program. Intermediate program outcomes for these risk groups can be compared to substantiated CPS referral or lack of substantiated CPS referral since entering the program.

Service Checklist. We developed the Service Checklist in collaboration with the steering committee and program staff to serve as a measure of types of services provided to

individual families by caseworkers. Steering committee discussions often returned to the question "what works?" As program interventions tend to be long, complex, and difficult to monitor (Lichstein, Riedel, & Grieve, 1994; Madaus, Stufflebeam, & Scriven, 1983; Sechrest et al., 1979) and the variation in interventions can be as great as the needs presented by the program participants (Lipsey & Cordray, 2000; Quay, 1979; Weiss & Rein, 1983), researchers needed a way to efficiently describe what was being done.

We reviewed sample case files and the community pages of the telephone book to create an extensive catalogue of services available in the region. Researchers used qualitative categorization to draft potential versions of a checklist. Drafts were presented to the evaluation steering committee for review and feedback. The steering committee and researchers worked together to group services into meaningful categories, deleting services for which the program was not responsible and adding services overlooked in the review process. Finally, exemplars were added to guide caseworkers in understanding the scope of specific services.

On the first draft of the service checklist, caseworkers were asked to indicate the approximate number of times that they helped the family with any of the 24 services listed on the checklist. When this draft was reviewed by the Steering Committee a caseworker suggested that this system of providing a gross count of the number of times that they "helped" the family did not give them "credit" for the level of help they had to provide to the family. The checklist was then broken into four service delivery modes: transportation to a service, intervention, information or support, and referral.

The service checklist with the service delivery modes was piloted by four of the ten caseworkers. Each worker completed the service checklist for one participating

family. Once the form was completed, the caseworker was asked to provide suggestions on how the checklist could be improved. Difficulties and confusions were noted and final changes were made based on this information.

The final Service Checklist took the form of a matrix with 24 rows listing specific services and four columns provided to describe the way in which the specific services were delivered to the program participants. Service delivery modes included the following: a) transportation to and/or from services, b) intervention by the Worker, c) information and support from the Worker, and d) referral to another provider or agency. These service delivery modes provided an indication of the level at which the intervention was provided. The 24 specific services were further grouped into six major categories of service: financial services, employment services, health services, relational services, academic services, and legal services. These categories summarize the areas integral to the program's goals and therefore the areas for which data were needed on all program participants.

Data from this checklist are used to assess what services caseworkers are delivering to program participants and how they are delivering the services. Analyses of what services are provided to program participants with different initial risk levels and different intermediate child maltreatment outcomes provide insight into the effectiveness of processes.

RESULTS

The 24 specific services listed on the service checklist were collapsed into six categories of service. These categories of service are reported on across three of the four

service delivery modes listed on the checklist. The transportation service delivery mode category will not be used in this analysis. The top five services delivered to program participants were information or support for relational services (n = 88 , 72%), referral to relational services (n = 63 , 52%), information or support for health related services (n = 58 , 48%), information or support for financial services (n = 57, 47%), and referral to financial services (n = 57 , 47%). The percentage of services delivered at least one time to each of the program participants in the sample are presented in Table 1. The minimum and maximum number of times that children received the services are provided in parentheses underneath the percentage. This table also details which of the 24 specific services compose each of the six categories of service.

We set out to determine whether program participants initially classified as low or high risk received different services. We used data from the Child Abuse and Neglect Form and the service checklist to answer this question. Analysis of the different services provided to clients was also examined in light of whether maltreatment occurred after entering into the program.

The initial risk level of program participants was determined by the caseworkers' responses regarding substantiated CPS referral on the Child Abuse and Neglect Form. Children with a previous substantiated CPS referral were classified as "high initial risk " (n=35), all others were classified as "low initial risk" (n=87). Type and delivery method of services was determined by caseworkers' estimates on the Service Checklist of what services they provided to program participants.

We used an independent-samples t-test to evaluate the hypothesis that program participants with different initial risk levels received different types of services. The tests

demonstrated statistically significant differences in the services provided to program participants at high or low risk for child maltreatment. Program participants with high initial levels of risk received more information or support for relational services ($t_{(120)}$ = 2.871, p =.005), information or support for legal services ($t_{(120)}$ = 2.917, p = .005), referrals to financial services ($t_{(120)}$ = 2.195, p = .030), referrals to health services ($t_{(120)}$ = 2.183 p = .035), referrals to relational services ($t_{(120)}$ = 2.371, p = .022), and referrals to legal services ($t_{(120)}$ = 3.128, p = .003). In contrast, these high initial risk level program participants received less information or support for academic services ($t_{(120)}$ = 1.904, p = .060). These means and standard deviations related to the seven statistically significant differences are presented in boldface in Table 2.

We also set out to find out if program participants who achieved the program goal (reduced child maltreatment as defined by substantiated CPS referral) received different services than those who did not. Data were collected on CPS substantiated referrals since joining the program for 122 program participants. As we were interested in evidence of a significant difference between the services offered to one group (program goal achieved) and another group (program goal not achieved), an independent-samples t-test was again employed.

Program participants who achieved program goals received more interventions for academic services ($t_{(120)}$ = 3.803, p < .001) and more referrals to the academic category ($t_{(120)}$ = 3.097, p = .002). The means and standard deviations related to these two statistically significant differences are presented in boldface in Table 3.

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DISCUSSION

We set out to show that researchers can concisely describe and efficiently measure interventions provided by caseworkers in a broad-aim social program. This would ease the burden of measurement in a process-outcome evaluation. We also felt that by collaborating with stakeholders in creating instruments and by making the data collection process concise and efficient, program staff would be more open to using evaluation findings and engaging in post-evaluation self-study. This is only possible when all parties involved, evaluators and evaluatees, work together to define goals.

This paper detailed the researchers' work with the staff of a family preservation program to develop effective instrumentation for sustained use. We collaborated to identify constructs that were important to the program and provided them with intermediate outcome data. Similar results may be obtained in other situations, aiding other evaluators in linking interventions to outcomes.

In the example detailed above, statistically significant differences in service delivery were found based on data collected by two instruments. In the independent-samples t-test analysis, we demonstrated that different categories of service are delivered to different program participants. Program participants who varied in achievement of the program goal (reduced child maltreatment as defined by substantiated CPS referral) differed with regards to receiving interventions for and referrals to academic services. For program participants that presented different risk levels, services differed mainly with regards to referrals (financial, health, relational, legal) and information/support (relational, academic, legal).

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We believe that using this collaborative process can help other program evaluators address concerns with defining and describing specific interventions during program evaluation. We see other programs being able to replicate our experience and yield meaningful findings, as we did. The collaborative process, when combined with adequate training and discussion, offers the potential for lasting use of these instruments and the possibility of program staff linking interventions to outcomes on a regular basis.

In collaboration with program staff, we developed an instrument to assess the initial level of CPS risk and occurrence of child maltreatment and an instrument to identify the type and mode of services delivered. Using these two instruments, we were able to describe interventions as well as determining differences in the delivery of services to clients initially at different levels of risk and clients with different levels of intermediate goal achievement.

TABLES

Table 1

Percentages of Services Delivered at Least One Time to Children and Their Families with Minimum and Maximum Number of Times Services Were Delivered in Parenthesis

	Intervention	Information or support	Referral
Financial Services (food, clothing, housing, financial assistance and counseling, and transportation)	44% (0 – 12)	47% (0 – 12)	47% (0 – 4)
Employment Services (job training, gaining and maintaining employment, and work compensation)	5% (0 – 2)	17% (0 – 5)	2% (0 –2)
Health Services (mental and physical health, substance abuse, insurance, and disability)	12% (0 –6)	48% (0 – 6)	34% (0 –4)
Relational Services (child care, social leisure recreational, mentoring, and parenting skills)	39% (0 – 13)	72% (0 – 9)	52% (0 –3)
Academic Services (literacy and parent academics)	32% (0 – 6)	26% (0 – 4)	8% (0 –2)
Legal Services (child-related and parent-related legal issues, child custody and child support)	4% (0 –2)	21% (0 – 4)	11% (0 – 3)

Table 2

Means and Standard Deviations of Categories of Service and Service Delivery Modes for Program Participants with Different Initial Levels of Risk

	Intervention		**Information or support**		**Referral**	
	High Initial Risk	Low Initial Risk	High Initial Risk	Low Initial Risk	High Initial Risk	Low Initial Risk
Financial Services	$\bar{x}$ = 2.14 s = 2.97	$\bar{x}$ = 1.56 s = 2.90	$\bar{x}$ = 1.83 s = 2.60	$\bar{x}$ = 1.40 s = 2.35	**$\bar{x}$ = 1.23** **s = 1.24**	**$\bar{x}$ = .74** **s = 1.07**
Employment Services	$\bar{x}$ = .06 s = .34	$\bar{x}$ = .07 s = .30	$\bar{x}$ = .23 s = .77	$\bar{x}$ = .30 s = .75	$\bar{x}$ = .00 s = .00	$\bar{x}$ = .04 s = .24
Health Services	$\bar{x}$ = .51 s = 1.27	$\bar{x}$ = .18 s = .69	$\bar{x}$ = 1.20 s = 1.49	$\bar{x}$ = .99 s = 1.36	**$\bar{x}$ = .89** **s = 1.23**	**$\bar{x}$ = .40** **s = .71**
Relational Services	$\bar{x}$ = 1.60 s = 3.87	$\bar{x}$ = 1.75 s = 3.36	**$\bar{x}$ = 2.11** **s = 1.73**	**$\bar{x}$ = 1.26** **s = 1.37**	**$\bar{x}$ = 1.11** **s = 1.11**	**$\bar{x}$ = .63** **s = .75**
Academic Services	$\bar{x}$ = .31 s = .76	$\bar{x}$ = .62 s = 1.10	**$\bar{x}$ = .26** **s = .61**	**$\bar{x}$ = .54** **s = 1.00**	$\bar{x}$ = .58 s = .24	$\bar{x}$ = .13 s = .43
Legal Services	$\bar{x}$ = .14 s = .49	$\bar{x}$ = .23 s = .77	**$\bar{x}$ = .77** **s = 1.06**	**$\bar{x}$ = .21** **s = .68**	**$\bar{x}$ = .60** **s = 1.03**	**$\bar{x}$ = .04** **s = .26**

* homogeneity of variance assumption violated, equal variances not assumed reported

Table 3

Means and Standard Deviations of Categories of Service and Service Delivery Modes for Program Participants Who Do or Do Not Achieve Program Goals

	Intervention		**Information or support**		**Referral**	
	Program Goal Achieved	Program Goal Not Achieved	Program Goal Achieved	Program Goal Not Achieved	Program Goal Achieved	Program Goal Not Achieved
Financial Services	$\bar{x}$ = 1.67 s = 2.84	$\bar{x}$ = 2.25 s = 3.65	$\bar{x}$ = 1.46 s = 2.22	$\bar{x}$ = 2.08 s = 3.92	$\bar{x}$ = .86 s = 1.14	$\bar{x}$ = 1.00 s = 1.21
Employment Services	$\bar{x}$ = .06 s = .27	$\bar{x}$ = .17 s = .58	$\bar{x}$ = .24 s = .68	$\bar{x}$ = .67 s = 1.23	$\bar{x}$ = .03 s = .21	$\bar{x}$ = .00 s = .00
Health Services	$\bar{x}$ = .24 s = .75	$\bar{x}$ = .67 s = 1.78	$\bar{x}$ = 1.05 s = 1.34	$\bar{x}$ = 1.08 s = 1.93	$\bar{x}$ = .55 s = .91	$\bar{x}$ = .42 s = .90
Relational Services	$\bar{x}$ = 1.78 s = 3.58	$\bar{x}$ = 1.00 s = 2.59	$\bar{x}$ = 1.41 s = 1.34	$\bar{x}$ = 2.42 s = 2.61	$\bar{x}$ = .76 s = .87	$\bar{x}$ = .83 s = 1.11
Academic Services	**$\bar{x}$ = .58** **s = 1.06**	**$\bar{x}$ = .08** **s = .29**	$\bar{x}$ = .47 s = .93	$\bar{x}$ = .33 s = .78	**$\bar{x}$ = .12** **s = .40**	**$\bar{x}$ = .00** **s = .00**
Legal Services	$\bar{x}$ = .04 s = .23	$\bar{x}$ = .25 s = .62	$\bar{x}$ = .36 s = .84	$\bar{x}$ = .42 s = .90	$\bar{x}$ = .21 s = .65	$\bar{x}$ = .17 s = .58

* homogeneity of variance assumption violated, equal variances not assumed t reported

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APPENDIX A

Child/Family Name: _____
Child/Family Code: _____ Date Completed: _____ FSW Code: _____
School: _____ Data Coded By: _____ Date Coded: _____

Child Abuse & Neglect Study

Purpose: This form describes a child's history of abuse and neglect factors. It is completed for each child in the evaluation. In the event that you are unable to complete some of the CPS history items, please give this form to the program coordinator so that she can check the Central Registry or OASIS.

Directions: Please respond to each item in this instrument. You may need to consult with colleagues within the Department of Social Services. Fill this form out for each child in the family.

1. Was this child ever assessed or investigated by CPS prior to coming into the FSP?

Yes No

If yes,

a. What were the reasons? *Check all that apply:*

- ❑ Physical injury
- ❑ Mental injury
- ❑ Sexual abuse
- ❑ Physical neglect

b. Were the allegations substantiated?

Yes No

If yes, what were the outcomes? *Check one:*

- ❑ Did not become a CPS case
- ❑ Became a CPS case

If it became a CPS case, what resulted?

_____

_____

2. Has this child been assessed or investigated by CPS since coming into the FSP?

Yes No

If yes,

a. What were the reasons? *Check all that apply:*

- ❑ Physical injury
- ❑ Mental injury
- ❑ Sexual abuse
- ❑ Physical neglect

b. Were the allegations substantiated?

Yes No

If yes, what were the outcomes? *Check one:*

- ❑ Did not become a CPS case
- ❑ Became a CPS case

If it became a CPS case, what resulted?

_____

_____

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3. **Has this child been placed outside of the home by the courts prior to coming into the FSP?**

Yes No

If yes,

a. How many times? _____ (Dates: _____)

b. Where was the child placed? *Check all that apply:*

- ❑ Placement with relative
- ❑ In home placement
- ❑ Foster home
- ❑ Specialized/therapeutic foster home
- ❑ Residential placement
- ❑ Other: _____

4. **Has this child been placed outside of the home by the courts since coming into the FSP?**

Yes No

If yes,

a. How many times? _____ (Dates: _____)

b. Where was the child placed? *Check all that apply:*

- ❑ Placement with relative
- ❑ In home placement
- ❑ Foster home
- ❑ Specialized/therapeutic foster home
- ❑ Residential placement
- ❑ Other: _____

Directions: Please respond to the following questions based on your observations of the child since he or she first became involved in the Program. You might infer this information from conversations you have had with the caregiver and child about their typical daily schedules.

5. **Approximately how much time per day *Monday through Friday* does this child spend alone without a supervising adult?**

Little or none			A great deal of time
1	2	3	4

6. **Approximately how many hours per day *Saturday and Sunday* does this child spend alone without a supervising adult?**

Little or none			A great deal of time
1	2	3	4

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Directions: Please respond to the following questions based on your observations of the child and caregivers since they first became involved in the Program. Circle the number that best reflects your response.

Do one or more of the caregivers in the home…	*Seldom or never*			*A great deal of time*	*Don't know*
7. Engage in corporal punishment frequently?	1	2	3	4	5
8. Engage in harsh discipline?	1	2	3	4	5
9. Make degrading remarks about the child?	1	2	3	4	5
10. Raise his/her voice to the child frequently?	1	2	3	4	5
11. Elicit negative response (physical, verbal, etc.) from the child?	1	2	3	4	5
12. Maintain emotional and/or physical distance from the child?	1	2	3	4	5
13. Require the child to complete tasks that are not age-appropriate?	1	2	3	4	5
14. Allow the child to behave in ways that are not age-appropriate?	1	2	3	4	5
15. Act inappropriately toward the child in stressful situations?	1	2	3	4	5
16. Consider physical punishment to be the best response to child misbehavior?	1	2	3	4	5
17. Avoid interaction with others outside of the home?	1	2	3	4	5

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Service Checklist

Directions: In the chart below, indicate the approximate number of times that you helped the family in any of the following ways. If you did not help the family in the way listed, or it is not applicable, write "0". Indicate whether you referred the family for additional help by circling yes or no in the *Referred for Services* column. Refer to your notes and/or contact log to approximate numbers for each. Please record the number of times that you helped the family within the **past three months**.

	Provided Transportation (# of times in the past three months)	*Provided Intervention (# of times in the past three months)*	*Provided Information or Support (# of times in the past three months)*	*Referred for Services (Yes / No)*
Food (e.g. food bank, food stamps, free/reduced lunch, Meals-on-Wheels)				Yes / No
Clothing (e.g. charitable organizations)				Yes / No
Housing (e.g. Section 8, Temporary Shelter, landlord)				Yes / No
Mental health (e.g. hospitalization, counseling)				Yes / No
Physical health (e.g. eyeglass assistance, state/local hospitalization, physician, preventative care)				Yes / No
Substance abuse (e.g. management, programs)				Yes / No
Financial assistance (e.g. DSS financial services, Social Security, TANF, GR, CSA)				Yes / No
Financial counseling (e.g. credit counseling, financial institutions, budgeting, tax counseling/EIC)				Yes / No
Job training (e.g. employment agency, FOCUS, Piedmont Works, STEP, VIEW, One Stop)				Yes / No
Gaining and maintaining employment (e.g. applications, contacts, negotiating)				Yes / No
Work compensation (e.g. Unemployment, Workman's Compensation)				Yes / No
Transportation (e.g. JAUNT, Driver's Education)				Yes / No
Child care (e.g. respite care, day care, after-school care)				Yes / No
Social, leisure, recreational (e.g. 4H, Parks and Rec.)				Yes / No
Mentoring (e.g. Big Brothers/Sisters)				Yes / No
Literacy (e.g. library programs, after-school activities)				Yes / No
Child-related legal issues (e.g. courts, legal aide, police)				Yes / No
Parent-related legal issues (any other legal issue not directly involving the child)				Yes / No
Child custody (e.g. advocacy for child custody)				Yes / No
Child support (e.g. advocacy for child support, DSCE)				Yes / No
Parenting skills (e.g. anger management, FOCUS, parent support group, parent education group)				Yes / No
Parent academics (e.g. GED, continuing education)				Yes / No
Insurance (e.g. FAMIS)				Yes / No
Disability/Equal access (e.g. Interpreter Services, Services for the Hearing Impaired, ARC, DRS)				Yes / No

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